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ABSTRACT

Addressing the complexities of families facing substance abuse can help caseworkers in assessment and treatment-planning activities. Some basic information and skills that caseworkers and foster care parents can use in the assessment of addiction and treatment-planning decisions are presented in this training manual. The manual and training program builds upon earlier "Fostering Families" training programs in this area. The topics covered include: (1) Meeting the new client and the role of the practitioner; (2) The disease model of addiction, which outlines the specific effects of alcohol, various drugs, and their interactions with alcohol; (3) Assessment of addiction, including assessment tools for use with adults and adolescents; (4) Working with the addict; (5) Families and co-addiction, which provides guidelines for appropriate relationships with dysfunctional family members; and (6) Eight moves caseworkers can teach to make for more powerful people. Issues related to success for recovering substance abusers are presented as case vignettes. The manual includes detailed instructions for trainers, a timeline for the day, training competencies and learning objectives, teaching materials, a resource bibliography, and an evaluation form. (EMK)

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FOSTERING FAMILIES

ED 417 368

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Education and Research Institute for
FOSTERING FAMILIES

**A Specialized Training Program
Designed to Enhance the Competency of
Caseworkers, Adoptive & Foster Parents**

ALCOHOL AND SUBSTANCE ABUSE: CONFRONTING DIFFICULT FAMILIES

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ABOUT THE AUTHORS

Mona Struhsaker Schatz, D.S.W., Associate Professor in the Social Work Department, Colorado State University, Director of the Education and Research Institute for Fostering Families, a comprehensive family and child welfare training development project. Involved in social work and child welfare education; primary areas of expertise include (1) children's services and child welfare practice, child development and attachment disorder, (2) social work education and field education in social work, (3) social work theoretical development in generalist perspective at initial and advanced levels, and (4) policy and practice issues in child welfare and families. Areas of social work practice since 1972 include children and family services, home health care, and private practice. Since the early seventies, Dr. Schatz has worked in child welfare and children's services in Colorado and several other states. In the 1970's, she served as a foster parent. She has served as a member of the Colorado Child Welfare Advisory Committee. Dr. Schatz also trains professionals in Eastern Europe and Russia in family and child practice. She has published articles in Child Welfare and the Journal of Social Work Education, monographs, and several dozen original training manuals addressing the knowledge and skills to foster effective social work/human services practice and parenting.

Larry Denmark, Ed.D., Licensed psychologist. Received his Doctorate in Psychology, University of Northern Colorado. Earned his previous degrees from New York University. Currently, Dr. Denmark is the Clinical Director, Addictive Disease Unit and the Dual Diagnosis Program at Mountain Crest Hospital, Ft. Collins, Colorado. Also serves as the Clinical Director, P.O.P.S. (People Offering People Support) Program, Loveland R-2J School District and of the Center for Alcohol Education at Colorado State University. In Dr. Denmark's 30 years as a teacher, therapist, supervisor and consultant, he has worked with clients of every age and economic stratum. He is widely known for his focus in the fields of chemical dependency and clinical supervision. Dr. Denmark wrote, produced and hosted *Psychology and Living*, a one hour television show, aired from 1985-1986. In 1992, he wrote *Dual Diagnosis: A Manual for Patients and Staff*, with Ken Ash, M.D. Recently, he released *Buddas in a Bullfight: How to be with Kids who don't want to be with You*, with Mark Keller, M.A. These experiences have been the foundation for his work as a public speaker, adjunct professor and consultant to numerous businesses and social agencies. Member, American Psychological Association. Listed in Who's Who in the West. In 1987, he was selected for the first edition of Emerging Leaders in the United States. In 1992, Dr. Denmark was honored by Larico Youth Homes when it established the *Larry Denmark Award for Excellence in Counseling*. This award is presented annually to an outstanding staff member.

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Education and Research Institute for

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The Education and Research Institute for Fostering Families, located in the Department of Social Work at Colorado State University, is an education, training, and research center seeking to improve social work and human service practice with families, youth and children, particularly families and children at risk and challenged. Fostering Families's Institute works through the Colorado Human Services Training, Education and Research Consortium. This collaboration includes Colorado's Department of Human Services, other social work programs, and various training centers in Colorado.

This Institute serves as an umbrella organization for four programs: a stipend pre-employment program for social work students, a "core" worker training program in family casework practice, a foster parent core training program, and an extensive series of on-going in-service training programs. Begun in 1986, Fostering Families is deeply committed to serving families, children and youth. It does so through the development of highly experiential training programs that offer the most current knowledge for the field and offering an opportunity to test out different practice skills and intervention strategies available for the varied jobs in this arena.

FOSTERING FAMILIES is a unique opportunity for caseworkers and foster care parents to explore the many complex aspects of the child welfare including child abuse and neglect, family support and preservation, permanency planning, adoption and foster care delivery.

FOSTERING FAMILIES is specially designed in to meet the varying learning and educational needs of training participants. Each training sessions uses different teaching and learning approaches such as groups, role play, sculpting, discussion groups, and individual learning exercises.

FOSTERING FAMILIES is designed to foster "a partnership of skill" among the many professionals responsible for quality care for families and children in distress. Each training program seeks to provide an increased level of competence that can be shared by the varied professionals who may be working with a family or child.

FOSTERING FAMILIES is offered, in specific levels, as continuing education credit and upper-division college class work in the Social Work Department done in concert with the Division of Continuing Education at Colorado State University.

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INSTRUCTIONS FOR TRAINERS

Since 1986, Fostering Families has successfully designed and delivered training programs to thousands of workers and substitute care providers in child welfare. We have created a set of principles which infuse our training programs and serve as a philosophic base. Depending on the training program, some of these principles are addressed directly while others are reinforced. It is important to summarize the principles as a background to these instructions for the trainer.

Principle 1: First, our work with families and children who are served by public social services and the child welfare system, is extremely difficult and almost always stressful. These families frequently live in what is often termed "the culture of social and familial violence". These families and children live in an almost constant state of uncertainty-- experiencing great social and personal vulnerability, with few concrete resources to help them. By the time we see these at-risk families, they have experienced a great deal of tragedy, victimization, loss, social rejection, and defeat.

Principle 2: We recognize how difficult it is to deliver social work services in large, public bureaucracies, no matter how "nice" the individuals are. Bureaucracies are inherently cumbersome and often disregard the very people they should be serving, both their workers and their clients. Fostering Families believes we must be very attentive to these inherent flaws of bureaucracies and work intentionally toward minimizing these counter-productive effects. Training mirrors our environment(s); therefore, our training creates an environment and experiences that are validating and supportive of each participant. In training, we must repeatedly encourage efforts that build and sustain open communication and active problem-solving among all people. Attitudes such as blaming, and poor-me serve as self-fulfilling prophecies, and the resultant feeling of helplessness is draining and unproductive. Offering skills that improve communication, advocacy, networking, mediation, role clarification, team building, and professional relationships --helps build and foster effective practice.

Principle 3: A well of compassion and empathy must be built (brick by brick!) through the combination of daily practice, supervision, and training. We can not stay in this difficult work if we become strangled by our anger and disrespectful to the people with whom we work. We are not in our positions and roles to punish families and children. The atrocities and horrors that meet families and children in poverty and

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social violence can not be excused. Yet, caseworkers and substitute family environments, such as foster homes, are asked to look forward. Our job involves performing extensive assessments to identify where things are at the moment. Our job also requires us to repair what we can and fix what can be fixed. We must "make futures" for relinquished children and youth, etc. Our training must build our understanding, and most importantly, our skills to work effectively with these difficult families and children.

Purpose of the Manual

This training is built upon these principles. This training manual is a necessary tool for the trainer. In this section, we will describe how trainers can get the most out of this manual.

Serving equally as the trainees manual, this booklet is a rich, valuable resource for their future use and reference. Concepts, principles, knowledge, and skills central to the training are written in the manual. A great deal of supporting documentation is also provided. At times, we know a training program can neither give equal attention to all the concepts related to the topic, nor introduce each small detail tied to the area under consideration. Group training experiences rarely focus on mastery of minute details. The manual, however, gives added documentation--access to more in-depth information to the trainee for later reference. Trainees greatly appreciate these manuals and report referring to them regularly.

The training manual is designed for both the trainer and the trainee. In using this approach, we save both money and time. There is also certainly less needless duplication and confusion about what materials are needed by the trainer when going out the door for their training session. This approach supports our adult training model, and also creates a more egalitarian teaching environment, because the trainer and trainees have similar training materials.

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The Training Agenda and How to Organize the Training Session

1. Setting an Agenda

Use the *Table of Contents* as your training agenda. The only additions you will want to make are a "Welcome and Introductions" at the top of the page and decide where "breaks" need to be anticipated. Because you can select your time frame for delivering the training program, decide how much time you need for the different areas of the training. As a rule of thumb, consider that each Lecturette and its supporting materials require at least 30 minutes to two hours to deliver.

These training programs are designed as one or two-day training sessions. This meets the need expressed by many professionals to receive training without losing a great deal of time from their work situations, often difficult for family and child welfare workers. Further, home providers such as group home workers, foster parents, proctor parents, and others can rarely take more than a day away from their home and families.

2. Welcoming and Introduction

The training program should begin with the *Welcome* and Introductions, giving each new trainee an opportunity to initiate their own process of contributing to and participating in the training. This is very important to fostering an atmosphere of joint learning with a higher level of trainee participation. Also, through the trainer's positive and receptive attitude, s/he can create an environment of trust and safety which goes a long way to optimizing the training process and maximizing the participants' growth and learning.

3. Training Competencies and Learning Objectives

After the introductions, present the *Training Competencies and Learning Objectives*. A valuable rule for trainers is to "tell people what you are going to teach them, then teach them, and end with a summary of what was taught." At this early point, the

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trainer should leave an opportunity for trainees to add any "training agenda" items they feel are important during the training program. This models an empowering process for the trainees wherein they too can "construct" the learning process that they feel they need.

At times, the requests of trainees go beyond the training program as designed. This is okay. The trainer must simply acknowledge the interest of the trainee, pointing out that the training will probably not be capable of delving in the specific area requested. This approach also helps trainers assess if "unique" issues exist that may be related to a geographic area, a local program, etc., or whether a trainee has a personal issue that may potentially distract the learning experience.

4. Training Content

The ***training content*** that must be delivered by the trainer(s) is provided in the ***Lecturettes***. The trainer must be very comfortable and knowledgeable about the material provided in each Lecturette. These training programs are also designed for a training team including a professional social work trainer and a foster parent co-trainer. This approach illustrates the valuable contributions of substitute providers who often spend a great deal of time with children in their home, and who often face problems that do not have easy solutions.

The training program is designed for adult learners. Therefore, in initiating the learning process, use of "lecture-to-the-audience" is limited. No Lecturette area should require more than 20 to 30 minutes of this talking to an audience style. Rather, the training exercise(s) in the manual serve to initiate the learning process. The use of ***exercises, videos, case vignettes, boxes, and discussions*** foster the teaching process as well as reinforcing central training objectives.

When presenting material in the Lecturettes, supporting ***charts*** exist that summarize the key principles, concepts, and points. The trainer can invite the trainees to "follow along" on a chart. These charts are very useful to keep the trainer focused. They are easy to read and allow the trainer the needed "notes" for delivering a portion of the training in its entirety.

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Though this training program is thorough in its presentation of central principles, concepts, skills, and supporting materials, the trainer(s) must have qualifications that include a strong practice background in child and family practice. This is a very important. It is, in fact, where the material in the Lecturettes becomes grounded in reality and relevance to the trainee. This is also the juncture where the trainer makes the training come alive. It is accomplished by the integration of trainer's own experience which--uniquely personalizes to the specific needs of *this* audience. The trainer's unique experiences infuse a personal and timely energy into the teaching process.

The training manual is designed so trainees have everything they need in the manual including paper to write on! The left hand side of the Lecturette sections provides the central ideas relevant to the learning area. The right side inserts instructions for when to introduce training exercises, videos, group discussions, etc. The right hand side of the manual also offers space for trainees to take notes and, importantly, for the trainer to make their own notes. Worksheets often exist for an exercise so time is not wasted in handing out materials once the training experience has begun.

5. Written Evaluation

Each manual also includes a ***written evaluation***, asking in essence, if the training competencies and objectives were adequately delivered. This strategy is used as an initial accountability assessment. It determines if the training as designed was in fact delivered to the satisfaction of the trainees. It is not possible, in one or two day formats to evaluate much beyond this point without using pre- and post-evaluative tools or other forms of behavioral evaluation which can assess improved practice competence.

Following these guidelines can best optimize the likelihood of creating a highly effective training for every participant!

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ALCOHOL AND SUBSTANCE ABUSE: CONFRONTING FAMILY DIFFICULTIES AGENDA

9:50-10:15 FILL OUT QUESTION CARDS "DEAR LARRY"

10:00	**WELCOME** Administrative details: Attendance Sheets/sign in; Mileage for County folks; Lunch-Any veggie's? CEU credit; Attendance Requirement Introductions of training staff
10:15	Trainee Introductions Trainer Introduction
10:40	Review Agenda for Day and Training Competencies
10:50	Review of Disease Model Issues that complicate our understanding of disease model Issues of assessment Working with how to help clients "Dear Larry" responses
11:55	LUNCH
1:00	Assessment Process and Issues Use vignettes
2:15	BREAK
2:25	Working with families/addicts Use vignettes
3:40	Evaluation Administrative Details
4:00	END OF THE DAY

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INTRODUCTION

The Education and Research Institute for Fostering Families is a specialized child welfare, adoption and foster care training program. Various important learning concepts related to families, youth and children are explored *within* the context of services to families and children and protective services more specifically. By paying specific attention to the multiple environments within which we work, Fostering Families' training is highly innovative and relevant for public and private sector caseworkers, case aides and foster parent providers including group and residential care specialists. Fostering Families is also unique because faculty and foster parent training staff receive regular input from different parts of the social services system and from foster parent providers who work daily to meet the needs of children in out-of-home placement and at risk of removal from the family-of-origin.

A primary goal of the training program is to examine different issues and intervention models in a relatively small group training experience. Each training program provides information that increases our understanding about the knowledge, concepts, and ideas that undergird an aspect of practice and the skills to improve (1) the assessment and placement process with families and children at risk of placement or involvement in a family preservation program, (2) the overall case planning, monitoring and supervising process, and, (3) the recruitment and retention of foster homes and other out-of-home providers.

Foster parents and caseworkers learn collaboratively in each session. Each training module is designed to motivate participants to go beyond transmission of information to training opportunities created so that trainees can apply concepts either in role play situations, small group experiences, group discussions, and/or through individual activities. Participants are given the opportunity to integrate their learning through discussion and group experiences. Training sessions are scheduled regularly throughout the year and are each one-day sessions. To achieve high accessibility for foster parent providers, training sessions are often held on weekends. To afford access to caseworkers, sessions are also scheduled on weekdays. Each week training sessions are held throughout the urban, suburban and rural areas of the State.

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Introduction

Alcohol and Substance Abuse: Confronting Family Difficulties **builds upon earlier Fostering Families' training programs in this area. Addressing the complexities of families facing substance abuse can help caseworkers in assessment and treatment planning activities. Issues related to success for recovering substance abusers will be examined through case vignettes.**

This manual is written to provide information on the concepts and issues we have discussed in this training. A Suggested Resources section lists some interesting reading related to this topic area.

In the training session it is unlikely that all the information provided will be entirely addressed. We recommend trainees read these materials soon after the training session. We have been told that this helps greatly in gaining a full understanding of the issue at hand.

We welcome you to this Fostering Families training session. We encourage you to participate fully in the training; ask questions that help you (and others) in this interesting and challenging learning opportunity. Colorado State allows participants opportunity to earn continuing education credit (CEU's) or university credit. The training instructor will review procedures for applying for credit.

The best advise we can offer to work with today's agenda is to feel comfortable asking questions where helpful, get as relaxed as possible, and enjoy yourself!!

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TRAINING COMPETENCIES & LEARNING OBJECTIVES

The primary purpose of this module is to provide caseworkers and foster parents with basic information. This purpose also addresses skills that will enable them to better assess the needs of families and children, make more appropriate treatment planning decisions, and carry out their professional roles in a manner that reflects greater sensitivity to families and children that are abusing addictive substances. The competencies to achieve and learning objectives for training participants are as follows:

1. **Identify and recognize denial as a primary factor in addressing substance abuse issues in child protection.**

2. **Distinguish between social use and addictive use of mood-altering substances.**

3. **Learn new ways to relate to client family members in the interview and assess the needs of family members.**

4. **Be able to identify the complexities for assessment and treatment planning with client family members with dual and multiple diagnoses where one of the diagnoses is substance abuse.**

5. **Gain competence in planning treatment strategies using knowledge of different levels of treatment intervention, and thereafter succeeding in the monitoring and coordination of the case plan.**

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THE PRACTITIONER: MEETING THE NEW CLIENT

Lecturette #1

It is important in beginning this training to understand the trainer. Who is the person who would stand up in front of a group of social services/child services professionals and parents and discuss the difficulties of families who are substance abusers? On the next page, please read the story by co-author Dr. Larry Denmark. He describes well the kinds of experiences that contribute to being successful when working with substance abusers. He illustrates for us so keenly the thoughts that exist when considering our initial work with a client and the feelings of anxiety and anticipation present when beginning to work with any new family or individual.

Individual/Group Activity:

Introductions of participants

Identification of what areas for learning training participants want to address.

Fill out cards with questions for trainer.

Individual/Group Activity:

Read Box One and discuss as a group.

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BEING A SUBSTANCE ABUSE COUNSELOR

Box One

Picture Somerset, Pennsylvania. It's 1975. Along a major access road, there is a 40 bed rehabilitation center in an old building, once a motel. The program rents this facility for one dollar a year. This region is in the Appalachian Mountains where there are two seasons--August and winter.

The counselors are all recovering alcoholics. I am the new psychologist. For once in my life, I decided to keep my mouth shut and listen--and learn as I experienced the day to day actions of clients and colleagues. And, they taught me--taught me their theory of counseling alcoholics. They called it "beating up drunks."

Today, some twenty years later, I have helped a few of the thousands of alcoholics and drug addicts that I have seen. They have given me many blessings--something I had not expected when I first began in this field. Equally important, a big part of the good parts of who I am today, I have learned from those drunks and junkies.

When I reflect on my work today, I always know to begin at the beginning. In my first interview with the client and/or the client and family I am loaded with anticipation. There will be drama, and, maybe, some magic. The clients are all quite certain about what's wrong and about what to do. Of course, if their theories were correct, they never would have met me!

I sit with the new client. I smile. I sweat. I wonder. . . who is this person(s)? What keeps him or her together? What's driving this couple or family apart? Why does this person cling so tenaciously to their misery? How can I possibly help?

I talk to myself, internally. "Stay loose. Stay open. Stay flexible. Listen--always listen. Be friendly. Don't try to fix it all at once. Stay here. Feel it. Love him!"

As quickly as I can, I ascertain a tentative diagnosis and a preliminary plan. There will be homework. I work hard to let him or her know I'm interested in them. Yes, I can do it. I can stick it out. And, I can haul the freight!

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THE DISEASE MODEL OF ADDICTION
Lecturette #2

Among armchair philosophers there are many explanations of alcoholism, and equally as many theories about intervention--the "how to" of "curing" this abuse. In the trenches, where drug and alcohol counselors make their living going nose-to-nose with abusers sufferings, the disease concept is virtually universal. The disease concept, accepted by the American Medical Association in 1955 and retained presently, states that "alcoholism is a disease that is chronic, progressive and incurable".

"Chronic" means that once a person gets the disease, they will always have the disease. Said a bit differently, once the pilot light is lit, it never goes out! A person's only choice is whether or not to throw gasoline on the little flame and make it much more dangerous, less controllable.

"Progressive" also important in understanding the disease concept, means that the disease always gets worse and never gets better. Even after a long period of sobriety, an alcoholic will quickly discover, if s/he experiments, that drinking progresses and can't be stopped. The consequences get bigger, too.

"Incurable" means that an alcoholic can never be cured.

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The Disease Model of Addiction

Lecturette #2 (con't)

Once a person is an addict, the ability of the person to use mood and mind altering substances does not exist. Many thousands have literally died trying, however.

Is there some good news? Maybe. Alcoholics can recover. In clinical observations, it is seen that recovering alcoholics lead extremely meaningful lives when living in sobriety. This group of individuals becomes responsible for their choices, whereas most of society just muddles through.

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Alcoholism and drug addiction is a disease, it has its own symptoms and is describable like measles and diabetes. Different dimensions of the disease include the following:

A. **PRIMARY DISEASE:** Not a secondary symptom of something else.

B. **PROGRESSIVE DISEASE:** Gets progressively worse; person becomes physically, spiritually, emotionally, and psychologically ill.

C. **CHRONIC DISEASE:** No cure; relapse is part of disease. Once manifested there is no way to reverse the body's chemistry to enable one to drink or intake drugs safely.

D. **FATAL DISEASE:** The disease can only be arrested, put in remission; gone unchecked person will die or die from the associated addicted lifestyle. (falls, car wrecks, violence)

The continuum of use, the stage and rapidity, depends on the combination of the above mentioned factors. Also, like diabetes, chemical dependency is a multifactorial disease. The biopsychosocial model (Engel, 1977) illustrates the factors that add up to chemical dependency.

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CHEMICAL DEPENDENCY 101

Chemical dependency is an equal opportunity disease, it transcends all socio-economic, cultural, racial, and demographic lines. The following are some risk factors to consider:

* family history of alcoholism
* family history of criminality or anti-social behavior
* problems of parental direction or discipline
* parental drug use or parental attitudes approving use
* peer group use, friends and siblings
* learning difficulties, unsuccessful school experiences
* social isolation and alienation
* significant low self-esteem
* anti-social behavior during early adolescence
* poor impulse control, inability to delay gratification
* age of first use, early experimentation (pre 11-14)
* history of emotional, physical, and/or sexual abuse

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ALCOHOL INTERACTION WITH OTHER DRUGS[1]
Chart A

Category	Drug Name	Interaction Effects with Alcohol
Tranquilizers	Valium, Midtown, Librium, Xanax, Tranzene	Decreased alertness and judgement can lead to dangerous household and auto accidents; potential for lethal dosage when used in large quantities
Over-the-counter pain killers	Aspirin, Bufferin, Excedrin, Alka Seltzer, Empirin, etc.	Increases likelihood of irritation and bleeding in stomach and intestines; can lead to liver damage
Prescription pain killers	Demerol, Darvon, Codeine, Percodan, etc.	Reduces the central nervous system's functioning which can lead to respiratory difficulties and/or death
Stimulants	Caffeine, Ritalin, diet pills, Benzedrine, etc.	Can cause a false sense of alertness without actually improving ability to function and control fine motor movement
Barbiturates	Phenobarbital, Secanol, Nembutal, other sedatives	Can cause respiratory failure, coma, and/or death
Antihistamine	Dimetapp, Dristan, Contac, Nyquil, etc.	Can exacerbate drowsiness and loss of alertness normally affected by these medications alone
Psychotropic Medications	Thorazine, Prolixin, Sparine, etc.	Addictive depressive effect on central nervous system which may lead to difficulty with walking and use of hands; can lead to respiratory failure, liver damage, and death
Antibiotics	Erythromycin, Flagyl, Tetracycline, Fulcin, etc.	May cause nausea and vomiting, especially with drugs used for urinary tract infections
Hypertensive Medications	Capoten, Aldomet, Inderol, diuretics, like Diural, Hydromax, etc.	Can lower blood pressure to cause dizziness upon standing and possibly hypotension which is a dangerously low blood pressure level

[1]Source: Lee Nutter, Ph.D. et. al., *Alcohol and Other Drugs in the Practice of Child Welfare*, Arizona Dept. of Economic Security: Administration for Children, Youth and Families, undated.

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BLOOD ALCOHOL LEVEL & DRINKING CONSEQUENCE[1]

Chart B

Blood Alcohol Level	Approx. # Drinks per hour	Behavioral Effects
.4 to .65	a pint +	Stuporous, no judgement, stage 1 anesthesia, amnesia, possible respiratory failure, coma, death
.3	15	Slurred speech obvious, stumbling, falling, nausea/vomiting, irritable
.2	10	Diplopia, slurred speech, ataxia, labile mood, erratic emotions, very poor coordination if any
.1	5	Poor/no judgment, poor coordination, inhibitions released, legally drunk, dizziness
.05	2	Judgement impaired, visual acuity reduced, smell & taste decreases, pain threshold up
.02	1	Relaxed

[1]Source: Lee Nutter, Ph.D. et. al., *Alcohol and Other Drugs in the Practice of Child Welfare*, Arizona Dept. of Economic Security: Administration for Children, Youth and Families, undated.

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SUMMARY CHART: ALCOHOL AND OTHER DRUGS[1]

Chart C-1

DEPRESSANTS	Prescribed Brand Names	Medical Uses	Other Names	Physical/Psychological Dependence & Tolerance	Effects (in hours)	Approximate Detection Time in Urine	Usual Method of Administration	Possible Effects	Overdose	Antidote	Withdrawal Symptoms
Alcohol	None	None	Liquor, Beer, Wine	High / Yes	1 to 12	3 to 4 hours	Oral				
Chloral Hydrate	Notec Somnos	Hypnotic		Moderate / Probable	5 to 8	no data	Oral				
Barbiturates	Amytal, Butisol, Nembutal, Phenobarbital Seconal, Tuinal	Anesthetic, anti-convulsant sedation, sleep	High, barbs, downers, reds, yellow jackets, blue devils	High / Yes	1 to 16	short acting, e.g., seco barbital 1 day	Oral, injected	Slurred speech, disorientation, drunken behavior, loss of coordination, impaired reactions	Shallow respiration, cold and clammy skin, dilated pupils, weak and rapid pulse, coma, possible death	Empty stomach, maintain body heat, artificial respiration	Anxiety, insomnia, tremors, delirium, convulsions, possible death
Glutethimide	Doriden	Sedation, sleep		High/yes	4 to 8	no data	Oral				
Methaqualone	Optimil, Parest, Quaalude, Somnafac, Sopor	Sedation, Sleep	Ludes	High/yes	4 to 8	14 days	Oral				
Tranquilizers	Equanil, Librium, Miltown, Serax, Tranxene, Valium	Anti-anxiety, muscle relaxant, sedation	Tranks,downers, blues, yellows	Moderate/yes	4 to 8	3 days	Oral				
Other Depressants	Clonopin, Dalamane, Dormate, Noludar, Placydil, Valmid	Anti-Anxiety, sedation, sleep	Possible/yes	4 to 8		Oral					

[1]Source: Lee Nutter, Ph.D. et.al., *Alcohol and Other Drugs in the Practice of Child Welfare*, Arizona Dept. of Economic Security: Administration for Children, Youth and Families, undated.

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SUMMARY CHART: ALCOHOL AND OTHER DRUGS[2]

Chart C-2

CANNABIS											
	Prescribed Brand Names	Medical Uses	Other Names	Physical/ Psychological Dependence & Tolerance	Effects (in hours)	Approximate Detection Time in Urine	Usual Method of Administration	Possible Effects	Overdose	Antidote	Withdrawal Syndromes
Marijuana	None	None	Pot, grass, reefer, sinsemilla, THC, weed	Degree Unknown Moderate/yes	2 to 4	Acute Dosage Joints = 2-3 Chronic (5 + joints) = 14-18 days Oral Ingestion 1-5 days	Oral, smoked	Euphoria, relaxed inhibitions, increased appetite, disoriented behavior, increased heart and pulse rates	Fatigue, paranoia, possible psychosis, time disorientation, slowed movements	Emotional Support; quiet, darkened room; avoid threatening behavior	Insomnia, hyperactivity and decreased appetite reported in a limited number of individuals

[2]Source: Lee Nutter, Ph.D. et.al., *Alcohol and Other Drugs in the Practice of Child Welfare*, Arizona Dept. of Economic Security: Administration for Children, Youth and Families, undated.

SUMMARY CHART: ALCOHOL AND OTHER DRUGS[3]

Chart C-3

HALLUCINOGENS											
	Prescribed Brand Names	Medical Uses	Other Names	Physical/ Psychological Dependence & Tolerance	Effects (in hours)	Approximate Detection Time in Urine	Usual Method of Administration	Possible Effects	Overdose	Antidote	Withdrawal Syndrome
LSD	None	None	Acid	None/ degree unknown/ yes	Variable		Oral	Illusions & hallucinations (with exception of MDA, poor perception of time and distance	Longer, more intense "trip" episodes, psychosis, possible death	Emotional support, quiet, darkened room; protect from self-injury	Withdrawal syndrome not reported
Mescaline and Peyote	None	None	Mesc, buttons, cactus				Oral, injected				
Psilocybin Psitocyn		None	Magic mushrooms, V], <K				Oral				
MDA	None	None					Oral, injected				
Phencyclidine	Sernylan	Veterinary Anesthetic	PCP, Angel Dust, Killer Weed, Hog			8 days (overdose)	Oral, Injected				
Other Hallucinogens	None	None					Oral, Injected				

[3]Source: Lee Nutter, Ph.D. et.al., *Alcohol and Other Drugs in the Practice of Child Welfare*, Arizona Dept. of Economic Security: Administration for Children, Youth and Families, undated.

SUMMARY CHART: ALCOHOL AND OTHER DRUGS[4]

Chart C-4

INHALANTS											
	Prescribed Brand Names	Medical Uses	Other Names	Physical/ Psychological Dependence & Tolerance	Effects (in hours)	Approximate Detection Time in Urine	Usual Method of Administration	Possible Effects	Overdose	Antidote	Withdrawal Syndromes
Nitrous Oxide	None	Anesthetic	Laughing gas Whippets	Possible/ Unknown/ Probable	Up to 5		Inhaled	Excitement, euphoria, giddiness, loss of inhibitions, aggressiveness, delusions, drowsiness, headache	Loss of memory, confusion, unsteady gait, erratic heartbeat and pulse, possible death	Artificial respiration	Insomnia, decreased appetite, depression, irritability, headache
Butyl Nitrite		None	Locker room, rush								
Amyl Nitrite		Heart Stimulant	Poppers, Snappers								
Chlorohydrocarbons		None	aerosol paints, cleaning fluid								
Hydrocarbons		None	gasoline, glue, paint thinner								

[4]Source: Lee Nutter, Ph.D. et.al., *Alcohol and Other Drugs in the Practice of Child Welfare*, Arizona Dept. of Economic Security: Administration for Children, Youth and Families, undated.

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SUMMARY CHART: ALCOHOL AND OTHER DRUGS[5]

Chart C-5

NARCOTICS	Prescribed Brand Names	Medical Uses	Other Names	Physical/Psychological Dependence & Tolerance	Effects (in hours)	Approximate Detection Time in Urine	Usual Method of Administration	Possible Effects	Overdose	Antidote	Withdrawal Syndromes
Opium	Dover's Powder, Paregoric	Analgesic, Antidiarrheal	Parepectolin	High/yes	3 to 6 hours	2 days	Oral, smoked	Euphoria; drowsiness, respiratory depression, constricted pupils, nausea	Slow and shallow breathing, clammy skin, convulsions, coma, possible death	Maintain body heat, artificial respiration	Watery eyes, runny nose, yawning, loss of appetite, irritability, tremors, panic, chills and sweating, cramps, nausea
Morphine	Morphine	Analgesic	Pectoral syrup	High/yes	3 to 6 hours	2 days	Injected, smoked				
Codeine	Codeine	Analgesic, antitussive	Robitussin A-C, Empirin compound with codeine	Moderate/yes		2 days	Oral, Injected				
Heroin	None	None	Horse, Smack, H, Junk	High/yes	3 to 6 hours	2 days	Oral, sniffed, Oral, injected				
Meperidine (Pethidine)	Demerol, Pethadol	Analgesic				no data					
Methadone	Dolophine, Methadone, Methadose	Analgesic, heron substitute	Dolly	High/yes	12 to 24 hours	3 days	Oral, injected				
Fentanyl, Other Narcotics	Dilaudid, Leritine, Numorphan, Percodan	Analgesic, antidiarrheal, antitussive	China white, Juice, Ds, Percs	High/yes	3 to 6 hours	no data	Oral, Injected				

[5]Source: Lee Nutter, Ph.D. et.al., *Alcohol and Other Drugs in the Practice of Child Welfare*, Arizona Dept. of Economic Security: Administration for Children, Youth and Families, undated.

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SUMMARY CHART: ALCOHOL AND OTHER DRUGS[6]

Chart C-6

STIMULANTS											
	Prescribed Brand Names	Medical Uses	Other Names	Physical/Psychological Dependence & Tolerance	Effects (in hours)	Approximate Detection Time in Urine	Usual Method of Administration	Possible Effects	Overdose	Antidote	Withdrawal Syndromes
Cocaine	Cocaine	local anesthetic	Coke, Flake, Snow	Possible/high/yes	2	2 - 4 days	Injected, Sniffed	Increased alertness, excitation, euphoria, dilated pupils, increased pulse rate and blood pressure, insomnia, loss of appetite	Agitation, increase in body temperature, hallucinations, convulsions, possible death, tremors	Supportive care, medical attentions, check for shock	Apathy, long periods of sleep, irritability, depression disorientation
Amphetamines Methamphetamines	Benzedrine, Biphetamine, Desoxyn, Dexedrine	Hyperkinesis, narcolepsy, weight control	Speed, Uppers, Crank, Crystal, Meth, Pep pills, Whites, Hearts, Black Beauties, Footballs	Possible/high/yes	2 to 4	24 - 48 hours	Oral, Injected				
Phenmetrazine	Preludin	Weight control		Possible/high/yes	2 to 4		Oral				
Methiphenidate	Ritalin	Hyperkinesis		Possible/high/yes	2 to 4		Oral				
Other Stimulants	Bacarate, Cylert, Didrex, Ionamin, Plegine, Pondimi, Sanorex, Veraril	Weight Control		Possible/high/yes	2 to 4		Oral				
Nicotine	None	None	Tobacco, cigars, cigarettes, snuff	High/high/yes	2 to 4		Smoked, Chewed	Increased alertness, excitation, euphoria, dilated pupils, increased pulse rate and blood pressure, insomnia, loss of appetite			
Caffeine	None	None	Coffee, tea, hot chocolate, soft drinks, No-doz	low/low/probable	2 to 4		Oral				

[6]Source: Lee Nutter, Ph.D. et.al., *Alcohol and Other Drugs in the Practice of Child Welfare*, Arizona Dept. of Economic Security: Administration for Children, Youth and Families, undated.

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ASSESSMENT OF ADDICTION
Lecturette #3

Caseworkers in public social services agencies and workers in child placement agencies are often consumers of case assessments. They also have responsibility for developing family and child assessments. Workers often wonder "how do I know if this assessment is accurate and complete?" Frequently we find that experts from the drug and alcohol community see clients as "addicted" while experts from the mental health community see the same individual as "not addicted to substance(s) but with a DSM-IV mental health diagnosis." Can one specialist diagnose someone as being addicted and another not? Is the "addiction" a "cause" or a "symptom"? Who should we believe? What can be done to clarify this situation?

When considering the assessment of family members, some guidelines help. First, consider picturing a three-legged stool. Like that stool, a good assessment should rest on three legs--or three types of information. The three types of information are (1) history and general background, (2) clinical impressions, and (3) objective testing. If an expert omits any one type of information, the conclusions of their assessment are probably shaky, jeopardizing the potential for successful treatment, leaving the client potentially unstable. Let us examine each of these areas briefly.

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Assessment of Addiction

Lecturette #3 (con't)

History and General Background

From grandparents to grandchildren, from cousins to uncles and aunts, from siblings to parents, we must examine who these family members are and what they and their daily living patterns represent for the wholeness of the family. What patterns exist in the family such as illness, addiction, abandonment, etc? What stories illustrate the functionality of the family and its members in carrying out the basic requirements of family life?

Three areas are crucial and recurrent as we assess substance use and abuse. Are there drinking problems, mood disorders, and/or incarcerations of family members? With this information, we can gain an understanding of vulnerabilities in the family. This does not, however, represent inevitabilities! For example, if a parent was alcoholic, the odds of another family member becoming addicted is 5 times greater than the average person coming from a non-addicted family model. This addiction may not be to a like substance, yet, the pattern of using a substance to alter feelings is possible.

Examine vulnerabilities means understanding what contributes to the sense of uncertainty we are addressing. For example, families that move a great deal are more vulnerable as are families that are extremely isolated either by geographic area or environment.

Individual/Group Activity:

Examine the two assessment charts, "Drug and Alcohol Assessment Tool" and the "Drug and Alcohol Assessment Tool for Adolescents" on the next several pages. These can be used as a quick reminder of some of the basic information to address in the initial assessment process. These can be xeroxed and used as you need them.

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DRUG AND ALCOHOL ASSESSMENT TOOL
A Checklist - Chart D

I. General Use Pattern

What's used?
- __ alcohol: What Form?
  _____
- __ Rx drugs
- __ over the counter drugs
- __ street drugs

How used?
- __ when taken
- __ how much
- __ how often
- __ what social situations

Some effects?
- __ tolerance
- __ sneaking/gulping (evidence of guilt)
- __ blackouts
- __ passouts
- __ turning yellow

II. Recent Situational Indicators

- __ marital problems
- __ mood swings
- __ sleep dysfunction(s)
- __ withdrawn or growing isolation
- __ manifold physical complaints
- __ weight loss
- __ impulsive life changes
- __ sexual dysfunction

III. History-Behavioral

- __ prior treatment
- __ family d/a history grandparents to child
- __ d/a related arrests
- __ other legal history
- __ frequent M.D. changes
- __ poor job history
- __ withdrawal symptoms
- __ weekend d/a use
- __ overdoes history
- __ geographic cure

IV. History-Social

- __ use intensifies conflicts
- __ accused by others of d/a problem
- __ battering spouse or children
- __ children have legal or school problems
- __ use of d/a to alter mood
- __ use in given situation(s)
- __ DUI
- __ jocose
- __ bellicose
- __ lachrymose
- __ financial problems/ bankruptcy
- __ meteoric success
- __ denial or minimization

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DRUG AND ALCOHOL ASSESSMENT TOOL FOR ADOLESCENTS

A Checklist - Chart E

I. USE HISTORY

What's used?

- __ alcohol: What Form? _____
- __ Rx drugs
- __ over the counter drugs
- __ street drugs

How used?

- __ when taken
- __ how much
- __ how often
- __ what social situations

Some effects?

- __ tolerance
- __ sneaking/gulping
- __ blackouts
- __ passouts
- __ turning yellow
- __ use to alter mood
- __ overdose history
- __ accused by others of (drug & alcohol) d/a problems

II. HOME: Recent Situational Indicators

- __ weekend d/a use
- __ recent increased use
- __ odors of unknown origin
- __ pot in sock drawer
- __ drug/alcohol related arrests or other legal entanglements
- __ mood swings
- __ nightmares or other sleep dysfunction(s) such as insomnia or hypersomnia
- __ intensified conflicts
- __ withdrawn or growing isolation
- __ manifold physical complaints
- __ weight loss/gain
- __ impulsive life changes

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DRUG AND ALCOHOL ASSESSMENT TOOL FOR ADOLESCENTS

A Checklist - Chart E (con't)

III. FAMILY HISTORY

- __ battered parent
- __ physical/sexual abuse (battered child)
- __ neglect issues
- __ parents are using/recovering
- __ prior treatment
- __ family d/a history three generations d/a related arrests
- __ other legal history
- __ overdoes history
- __ family role: lost child; scapegoat; family hero; clown; caretaker; some mix?

III. SCHOOL

- __ significant change in achievement(s)
- __ learning disabilities
- __ aggressive level
- __ impulsivity
- __ truant
- __ ditches (time of day)
- __ late
- __ confused
- __ sleepy
- __ passive
- __ pot in school
- __ V.P.'s friend
- __ geographic educational cure

IV. SELF AND PEERS

- __ music
- __ posture
- __ eye contact
- __ moods
- __ curfews
- __ allowance
- __ job
- __ unkempt
- __ new crowd
- __ new hang-outs
- __ levi jacket in -30

V. CO-MORBID CONDITIONS

- __ all nighters
- __ runaway
- __ conduct disorders
- __ self-mutiliation
- __ victim
- __ suicide attempt(s)
- __ affective disorders

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Assessment of Addiction

Lecturette #3 (con't)

Clinical Impressions

With experience, the assessment specialist should be able to gain a "feel" or "sense" of the person they are interviewing. Are they anxious, depressed, swinging emotionally? Are they the type that is possibly addicted to a substance? Which substance(s)? Are they bipolar, or a personality disorder? These are important considerations for the clinician who works daily in the mental health and/or rehabilitation trenches.

Objective testing

Tests assessing mental well-being can be valuable checks and balances for assessment. Clinicians are human, and therefore, fallible. And, clients often present an initial view of themselves that is stronger than their more daily mode. Tests such as the MMPI-2 for adults and MMPI-A for adolescents area mental health assessment tools that seek to uncover both mental health and addiction problems.

Individual/Group Activity:

Examine the Exercise entitled "Exploring Our Own Family History."

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EXPLORING OUR OWN FAMILY HISTORY
Exercise #1

Instructions: Please take a few minutes to relax and listen as the trainer provides a guided exercise illustrating the family history assessment process.

Please sit back. . . Relax. . . If necessary, please uncross your arms and legs. Just let yourself relax. . . No one will touch you or disturb you in any way. Take a deep breather and then exhale. Do that again, more slowly this time . . . A deep breath in . . . a long, slow exhale. . . Just focus on my voice for the next several minutes.

Let's look at our family tree. Let's look at all those big branches and see who's there. Let's look all the way back to our grandparents. . . all the way down to the grandchildren. . . Let's notice our brothers, sisters, aunts, uncles, cousins, parents . . . everyone.

And, let's ask ourselves a few questions:

Were any of these folks really moody, depressed, or in any other way low energy?

Or, did any of these folks have amazing energy?

Were any of them real good drinkers, I mean really could put it away?

And, did anyone in the family spend time in prison?

You are looking for three things: moods, drugs and alcohol, and incarcerations. Sometimes in the days long gone by, people talked about nervous breakdowns, sanitoriums, things of this sort that suggested politely that someone in the family was "out of control or unable to maintain their daily lifestyle."

So, now let's slowly come back to the group. Maybe stretch one second. Then, maybe someone would like to share their insights about this exercise.

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Assessment of Addiction
Lecturette #3 (con't)

Examining Client's Problems

Looking at the problems of clients and determining whether there is an addiction problem is a crucial part of the assessment process. The rule: Keep it simple! If the client's alcohol or drug use creates problems in his/her life, or makes existing problems worse, there is almost always an addiction diagnosis.

What confounds this assessment? Denial! Denial is powerful as a coping mechanism in our culture generally, and even for experienced workers, deciphering "truth" versus "denial" is tricky! If the clinician suspects addiction, then it is probably true, even if all the facts and substantiating information is not there in the early assessment process. This is again, where we have to "feel" our way through the process.

Perhaps the assessment specialist determining whether there is a serious substance addiction problem believes there is also a mental health issue such as depression, mood disorder, etc. In these cases, we refer to the concept of a dual or multiple diagnosis for a client. It is not uncommon to find both types of diagnosis for clients using addictive substances.

"Keep it simple!"
If the client's alcohol or drug use creates problems in his/her life, or makes existing problems worse, there is almost always an addiction diagnosis.

Individual/Group Activity:

Take a few minutes to review the exercise entitled "Diagnosing Addiction: Case Vignettes."

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DIAGNOSING ADDICTION
CASE VIGNETTES
Exercise #2

Instructions: This set of case vignettes may be done in small groups or with the large group, depending on the size of the training group. The trainer should inform training participants how they should organize to carry out this exercise.

Trainees should examine each of the following vignettes and decide whether the person in the illustration is addicted or not.

Vignette #1: I once knew a farmer, a huge man over 6'6" tall. He only drank three times in his whole life. All three times, he ended up in jail.

Vignette #2: After numerous verbal battles with her husband, Shirley decided to stop drinking. She had money to seek help, but she decided was going "to do this" on her own. Four months later, at her daughter's graduation party, she scandalized her family by getting drunk and dancing on the piano.

Vignette #3: After his first high school "kegger," 16 year old John Jeffers comes home and throws up on the front steps of the house. He then throws up on the couch in the living room and passes out.

Vignette #4: When you put in the laundry, you notice something in a pair of socks you had picked up in your foster daughter's room. There is a baggie of something that looks like pot. Last week, she smelled "dirty" but you couldn't figure out what the smell reminded you of. You call the school counselor to find out if she's possibly a drug addict.

Vignette #5: Your husband comes home telling you he got stopped when he was driving home after work today. This is the second DUI he has received this year. He is very angry because the officer said he will have to appear in court and surrender his license.

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Frequently, we find major depression and alcoholism, bipolar affective disorder and alcoholism, post traumatic stress disorder, and drug addiction, or conduct disorder and marijuana addiction. In all these combinations both areas need strong, continuous and concurrent interventions.

Let's examine the dynamics of denial a bit further.

> Denial comes in two flavors--"not me!" and "it's not that bad!"

> Denial is to addiction what spots are to measles.

Denial

The cardinal symptom of addiction is denial. Denial is to addiction what spots are to measles. We often say that denial comes in two flavors--"not me!" and "it's not that bad!" We need to be able to hear denial no matter how it comes our way.

"Not me!" This is blatant, wall-to-wall denial. The person is perplexed that no one understands him/her or his/her situation.

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They are emphatic about this stance. It is very clear that all the problems stem from other people--a spouse, a child, a boss, a medical condition, etc. A crucial piece for the worker is to realize that denial is an unconscious process.

The client is lying, maybe about some of the facts or all of the facts. But the point is that the client really does not get it. S/he knows s/he's not addicted. "If only you could see that!"

"it's not that bad!" Minimization keeps the person from accepting personal responsibility for their drinking and/or drug abuse. The sun is creeping over the horizon here, so to speak. The client knows s/he has got a problem but s/he thinks s/he can still control it.

This person will say, "If I ever get that bad . . ," indicating some imagined or some poor unfortunate street bum. This supports the delusion that s/he still has power over the substance. It is no coincidence that the first step of Alcoholics Anonymous begins, "We admit we were powerless over alcohol--that our lives had become unmanageable."

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What works when confronted with denial?

Three tools are effective with denial--education, leverage, and non-judgmental attitude. These are important in our intervention kit. Let's consider each of these briefly.

Education

The facts about addiction and how addiction impacts daily functioning are important "basics" for educating our clients. There are many places where one can learn about addiction, yet, it is important to continue to learn and be updated on the changing nature of the field of addiction.

These facts should be presented in neutral tones, as if a professor talking to valued students. Often we must recognize that the information we are presenting is really new to the client. Sometimes our information sounds "wrong" to the person who has a different set of "facts" in their head.

Leverage

If we wait until an addicted client is "ready" for help, we may not ever help that person through their addiction, and the related daily problems s/he faces in everyday life.

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Assessment of Addiction

Lecturette #3 (con't)

Many counselors used to believe that alcoholics had to hit "rock bottom" before they could benefit from treatment. Modern addiction therapists see the situation differently. They believe their job is to help the client make *this* crisis their "rock bottom." The addiction therapist tries to raise the client's bottom so that they never have to lose their job, family, home life, health, self-respect, etc.

Toward this end, the addiction therapist utilizes whatever positive forces exist in the client's life-space to catapult him/her into treatment, thus, chinking away at the denial.

In general terms, examples might be supporting the employer to mandate treatment "or else", or making compliance with an Intensive Outpatient Program a condition of the client's continued custody of a child(ren), etc. Professionals who are trained only in mental health treatment are often shocked when they learn that addicts are often forced into treatment. Addiction counselors know that very few of their patients truly volunteer for treatment!

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Non-judgmental attitude

Failure to master the use of this tool, the avoidance of a judgmental attitude toward alcoholics and addicts, will undermine all progress! Chemically dependent people are usually adept at sniffing out negative attitudes, their self-esteem is often quite low, and they are very sensitive to potential rejection! Many times they have used this intuition to skillfully manipulate their way to their next drink, or next line of coke or heroin. If the worker feels, even buried way down deep inside, that the alcoholic in front of her/him is weak, or stupid, or morally bankrupt, the client will read it. And, this knowing undermines the relationship and any hope for progress and healing.

In this context, the disease concept is truly a lifesaver. When the caseworker internalizes that addicts have a disease that is chronic, progressive, and incurable, s/he knows at a deep level that s/he and her/his client are allies against the number one killer of Americans!

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Picture a grizzled old alcoholic. She's got more than ten years of sobriety under her belt. Her face shows the wear of many years of hard drinking, and even harder living, before sobriety took hold. She looks at a group of clients in therapy, the group she is leading. Maybe that group is made up of younger alcoholics and drug addicts, and their dress reflects a wide range of educational and vocational backgrounds. She looks every person in the eye. They listen intently as she says "we don't believe that addicts are bad people trying to learn how to be good; we believe they are sick people trying to learn how to be well!"

Loss of Control

Most confusing for workers is the subtle dance clients do with their loss of control over their drug of choice. At times, the person seems to be able to control their substance use whether that is drinking alcohol, smoking pot, or mainlining. Yet, days or weeks later, the person is spinning hopelessly out of control. When the person losses control, they take the treatment down in flames with them. The caseworker wonders, "When does the abuse become dependency?" "How can I tell if my client has crossed that imaginary line into addiction?

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In the late stages, it is easy. The alcoholic, sick and alone, with numerous treatment failures, drinks daily, just to get even. He doesn't even get a buzz anymore, just temporary relief from misery. But earlier in the disease stages, when treatment was more likely to be successful, when the family was not so damaged, when the person's resources were still in place--clearly discerning dependency is difficult.

The difficulty lies in the complexity of the individual as s/he encounters the disease. Here the worker must master subtle nuances in their work. The clinician must leave the world of "either / or" thinking, mastering comfort in the "grey" matter of life.

One critical aspect of clinical observation in the assessment of substance addiction, is to assess the aspect of control or lack of control in the client. Initially loss of control shows itself randomly, unexpectedly in assessment situations. It creeps in on cat's paws! The crucial distinction is that the client can no longer consistently control his drinking. Perhaps he goes F.A.C.-ing with his co-workers every Friday. One week he "goes a little over board," alarming his colleagues and himself. Next week he "watches it" and quits after one or two. His friends, and he, are very relieved! Then the very

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next Friday, he gets his first DUI (driving under the influence). Bad luck? An over-active police officer? After all, he can take a drink or leave it! He proved that last week, right?

Wrong! He is already over the line. His drinking has become a Russian Roulette game--sometimes his drinking is okay, sometimes its deadly!

Let's keep it simple. Suppose he went out for strawberry shortcake and coffee every Friday? One such day, he has an allergic reaction to the strawberries--hives, wheezing, an emergency room visit, expense, and embarrassment. Would he pass on the strawberry shortcake the next Friday? or would he just try a nibble? Sounds insane! Yes, addiction is not a mental health problem but it causes the kinds of crazy thinking and behaviors that are akin to mental illness.

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WORKING WITH THE ADDICT

Lecturette #4

Working with clients who have multiple problems and multiple treatment failures can lead caseworkers to experience feelings of hopelessness, burn out, and exasperation. What to do? What steps could reasonably lead to a successful conclusion?

In the vignette on the following page, we meet a man who is not easy for us to work with. This 50 year old male client has a history of treatment failures. We must watch closely for how the process of close questioning leads to a contract that can work. Note how the process reflects the key concepts of compliance and surrender. Notice also how earlier treatment failures are reframed and utilized as potential sources of crucial information. Lastly, this vignette underscores the importance of drawing the client into a contracting process based on mutual respect and negotiation.

Levels of Treatment Intensity

Though a discussion of treatment levels is lengthy, this will be a brief overview. Certain parameters have been omitted for the sake of clarity, e.g. biomedical conditions and complications. Basically treatment options fall into four categories: out-patient counseling, out-patient intensive treatment, in-patient, and residential. These are described below.

Individual/Group Activity:

Read Exercise on the next page.

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WORKING WITH THE CLIENT
Exercise #3

Instructions: Read the following case vignette which addresses issues of assessment, treatment planning, and monitoring with a client. Discuss the contracting process and the concept of surrender and compliance as described in this material.

Dave's now 50 years old. He has got white hair, looking like he just woke up, with a full, red face. He's feeling downcast. Hopeless. He has a congenital liver illness. When he drinks he gets very sick.

His most recent "slip" lasted 6 months. He feels especially defeated today because a year ago he was sober. He and Gloria were both working, and their 11 year old daughter, Linda, was going to school regularly. The family was doing better than it had been doing for quite some time.

He can't remember why he started drinking again or, even, why he took that drink.

I begin gently, as I visit with Dave in my office. I ask, "How're you doing, today?" and, "How was the treatment that preceded this last bout of addiction? I explore further, "What was strong about the previous treatment program(s)?" and "What might have been missed in the previous treatment, if anything?"

I am careful to not put down or criticize any previous therapy or therapists. Instead I find out what therapist behaviors seemed most helpful and supportive for him. This contributes to my thinking about potential treatment programs, current treatment approaches, therapist/counselor selection, etc.

I ask Dave, "What was missed?" Dave looks sad. He shakes his head and quietly says, "I dunno."

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So, I ask, "What was going on right before the relapse?" I ask if Dave was going to AA meetings, talking regularly with his sponsor, working the Twelve Steps. He replies, "Oh, no. I felt great then!" And, he brightens somewhat, then continues, "I was soaring! I didn't need the meetings anymore." I ask, "Whether family matters were changing for his wife or daughter?" And, again, he says he doesn't remember.

As he talks, he reveals that he began feeling a need for less extended hours of sleep. His brain was racing. His description illustrated an impulsivity, grandiosity, and poor judgement. He had never heard of Bi Polar Affective Disorder, or Lithium. I felt we were on our way--in a direction that might provide more long term support for Dave.

So, I ask, "What are we going to do now?" How could we move things along so he could contribute to the improved family functioning needed so Linda could be returned home? I explained that this goal was important to everyone in the family. We agreed to make a contract.

The Contract

Keeping the contract simple is ideal. Contracts usually begin with, ***"I'll know I'm done with treatment when...."*** We need to set some goals and create goals that are easily measurable. For example, while we support the idea behind "be a good dad," we would prefer something more behaviorally specific and measurable. So, a different goal statement might be "Attending one hour supervised visits with his wife each month for 6 months, where he comes sober, with either a children's book or a short activity that he can offer for the visitation time."

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Surrender and Compliance

All addiction treatment is encapsuled in the surrender and compliance process. Compliance is crucial in early recovery. Simply, compliance means doing what one is told. Compliance means doing what has been seen to work for millions of other men and women who were also addicts. For example, actually *going* to AA or NA meetings is much more important than *wanting* to go, or *planning* to go. The right action(s) comes first; the right attitude(s) follows!

By requiring random urine screens, signed meeting cards, monitored antabuse, pay stubs, etc. we are monitoring compliance with the contract and treatment plan. As practitioners, we want the client to personally feel they are gaining from, learning from, getting something from the meetings, the group treatment, etc. Yet, we require compliance through compliant behaviors.

Surrender is different. Surrender is a super positive blessed event. After many weeks, months, or even years of struggle, a client stops fighting recovery and "gives up." Or, maybe said differently, "gives in." This life-saving surrender consists of genuine open-hearted acceptance of his/her disease and the need for the recovery program required. Surrender leads to serenity, a feeling of tranquility in the face of life's calamities.

So, with Dave, we mutually negotiate a specific contract of compliant behaviors that lead to a set of measurable goals.

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Compliance means doing what has been seen to work for millions of other men and women who were also addicts

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The right action(s) come(s) first;

The right attitude(s) follow(s)!

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Surrender leads to serenity, a feeling of tranquility in the face of life's calamities.

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Out-patient Counseling

The least intense and least intrusive level of treatment, out-patient counseling usually includes one or two sessions per week, at least one hour in duration. The focus of this counseling is "on-going recovery issues". Often this treatment mode fits people in long-term sobriety or in the earliest stages of the disease. The basis of this treatment is that the client is very motivated, non-defensive, and has little trouble using the information and experience of counseling.

Tools at this stage also include education, 12-Step meetings, sponsors, homework assignments, contracts, journaling, monitored antabuse and/or urine-analysis.

This therapy can take up to two years, with increasingly infrequent meetings.

Intensive Out-patient Treatment

This level of treatment has patients in group therapy and/or educational group meetings for at least 2 hours per day, 4 to 5 days per week. This treatment approach provides greater support and supervision for patients who are at a greater risk of relapse. All the tools used in out-patient counseling are used in this treatment model.

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Group therapy provides and stimulates peer support and confrontation. Peers can learn from each other's failures and successes.

The intensity of treatment usually decreases gradually over the course of 6 to 12 months. Long-term aftercare groups might last two or more years, at least one meeting each week. All this treatment is joined with the regimen of 12-Step meetings, sponsors, etc.

In-patient Treatment

When the disease has a strong grip on the patient and/or the patient has previously failed at a less intensive level of treatment, hospitalization becomes appropriate. Self-destructive ideations or behaviors also necessitate inpatient treatment.
In the hospital, the treatment day runs from 7:00 A.M. to 9:30 P.M., virtually non-stop. In-patient treatment seeks to keep people safe, teach them the basic concepts of the disease and recovery, diagnose all relevant conditions, and begin treatment.

In-patient treatment is invaluable in breaking through denial and helping addicts to identify themselves as having the disease. Further, prescription medications such as anti-depressants can be tried and adjusted before discharge. Discharge to intensive out-patient treatment is standard. Another variation, <u>partial hospitalization</u> consists of sleeping at home but attending all hospital programming every day.

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FAMILIES AND CO-ADDICTION
RELATING APPROPRIATELY TO FAMILIES

Lecturette #5

Families are where we first learn who we are, learning about ourselves in relation to all other family members. We adopt the patterns of the family without question whether those patterns are most beneficial to us throughout our lives. We learn the family's patterns about how to behave, how to learn, how to interact with others, etc. Many of the most subtle family patterns are those which teach us how to handle our emotions and feelings internally and externally. What is interesting about families, where addictive substances play a central role in family life, is how the entire family patterns are re-defined by the very presence of the addictive person. We say that the entire family *system* has been impacted by the addiction. The family system changes to cope with the difficult family situation.

Most families who enter the child protection system have backgrounds where substances have been abused by parents and other adults close to the family. The children of these families struggle to make sense of the role these addictive substances play in the lives of their parents and other significant adults. Living with an addicted family member is very difficult. Many people describe the experience of living with an alcoholic or drug addict as "crazy

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making." The addict is unable to control themselves yet maintains a great deal of dysfunctional control over others in the family. This kind of dysfunctional family leads each member of the family to play out certain roles that actually support the addict's position in the family.

Popularly, we addressed this dynamic as co-dependency in the 1980's. A great deal of professional and popular literature emerged at that time describing co-dependency and co-addiction.

Co-dependency and co-addiction are similar terms describing how the family members in a family with an addict are themselves tied strongly together. They too are addicted by the very nature of the situation and that addiction makes everyone equally dependent on each other, even though the family situation is unhealthy.

The primary treatment goal for the addictive family is to learn to recover the feelings that have been buried or unavailable. As is stated in an earlier Fostering Families training program, ". . . what you live with you learn, what you learn you practice, what you practice you become, and what you become has consequences." (From *Breaking Down Difficult Family Patterns* (1993)

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Driving to her clients' home, the caseworker thinks back to her last visit. She can picture the two eldest children and remember their names. But the third kid, 'what was his name?' I can never remember his name, she thinks.

It sounds like fretting, but an important process is underway, a process of reflection toward re-considering diagnosis, leading to better involvement with the family, possibly more effective communication.

"Why can't I remember his name?" she asks. He's kind of cute and real quiet. Humm . . . I'll bet he's the lost child!" She smiles, certain now. "Yeah, that's it. Now, what was his name?"

Unable to remember, she pulls into the next gas station, quickly opens the case file and scans the face sheet. Daniel. "Got it!" She thinks to herself, she will make a point of not falling into the trap of losing Daniel. She'll use his name when she talks with him. She'll make sure to talk to him more than once or twice during her time with the family.

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Bradshaw (1988) says that many poorly functioning families create an illusion of love when they idealize and minimize, they dissociate so that they no longer feel anything at all, they numb out (p. 6)."

The Roles of the Co-dependent Family

A set of roles connecting together members of the family has become popularized. These roles are summarized in Charts F through K. These roles are discussed extensively in Fostering Families' training entitled *Breaking Down Difficult Family Patterns*.

Relating Appropriately to Family Members

Our job as practitioners is to relate appropriately to family members as we provide support and planning with them. In Chart F we will examine how practitioners can work to support clients, rather than enable them.

Hard-earned experience for this worker to learn that it is so easy to fall into the dysfunctional family roles. The lost child can stay lost with practitioners as well as family members if we do not reflect on how the roles influence our own interaction with family members.

Individual/Group Activity:

Examine the following Charts G through K entitled "Family Roles in Addictive Families."

Examine Chart F entitled "Guidelines for Appropriate Relationships with Dysfunctional Family Members."

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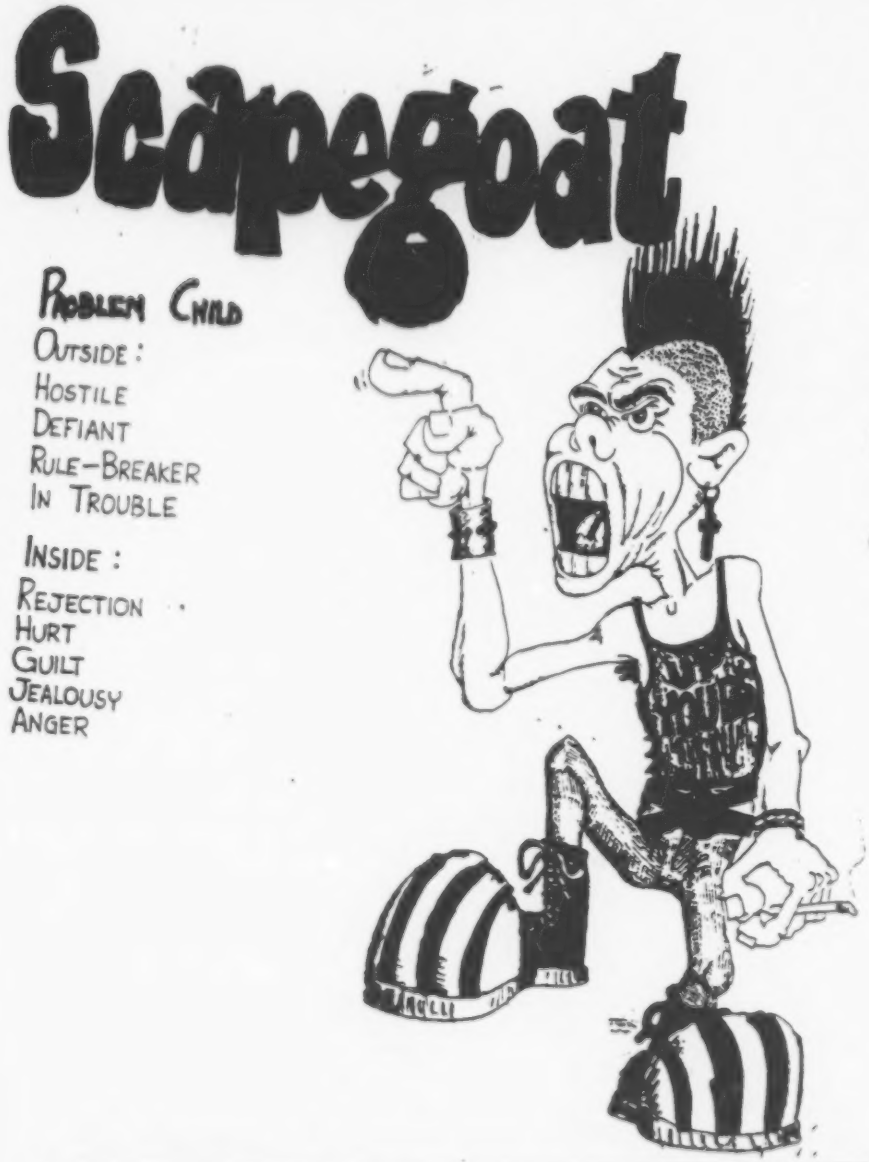
FAMILY ROLES IN ADDICTIVE FAMILIES
Chart F



The Scapegoat acts out family problems; the family blames this person for sadness or other difficulties. By distracting the family or keeping everyone so busy with their problems (e.g. legal problems, unplanned pregnancy or other crisis situation) the family does not have to look at the real problem(s). Outside they look hostile and defiant; they are rule breakers, get in trouble. Inside they feel rejected, hurt, guilty, jealousy, and anger.

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FAMILY ROLES IN ADDICTIVE FAMILIES
Chart G

The Family Hero
is an overachiever. They may have special talents and abilities. Often very rule bound. Outside they feel very responsible, needing recognition. Inside they feel inadequate, afraid, and have little fun.

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FAMILY ROLES IN ADDICTIVE FAMILIES
Chart H

The Mascot is the family favorite. Some are hyperactive or accident prone. She/he distracts the family or relieves the tension with humor or antics. Outside they sometimes look immature, fragile, hyperactive, or distracting. Inside they feel fear, anxiety, and insecurity.

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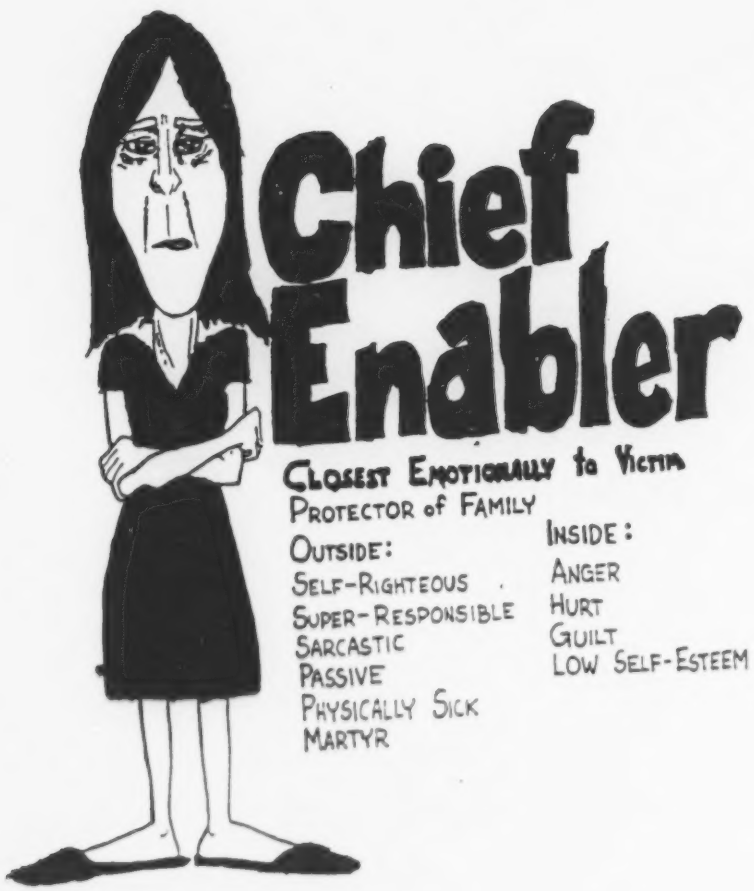
FAMILY ROLES IN ADDICTIVE FAMILIES
Chart I



The
Chief Enabler
adjusts to the addict, usually the spouse. This person forgoes meeting their own needs; keeps the addict "at a distance" from others when possible. Outside they seem self-righteous, super responsible, passive, and often physically sick. Inside they feel anger, hurt, fear, guilty, and have a low self-esteem. Also identified as family caretaker, martyr, among others.

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FAMILY ROLES IN ADDICTIVE FAMILIES

Chart J

The Addict (Victim) is the person who carries shame and pain. The person who is physically and/or emotionally involved with chemicals. Outside they look hostile, manipulative, aggressive, self-pitying, blaming, charming, and have rigid values. Inside they are actually feeling shame, guilt, fear, pain, and hurt.

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FAMILY ROLES IN ADDICTIVE FAMILIES
Chart K

The Lost Child causes no problems; spends a great deal of time alone, reading, listening to music, etc. Have low verbal skills, few friends. May be an overeater or overweight. Outside they appear shy, quiet, solitary, mediocre; have a fantasy life, attach to things rather than people. Inside they feel rejected, hurt, and anxious.

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GUIDELINES FOR APPROPRIATE RELATIONSHIPS WITH DYSFUNCTIONAL FAMILY MEMBERS

Chart L

ROLE/Practitioner's Response	Guidelines for Practitioner Behaviors
SCAPEGOAT "Bummer dude..."	Don't rescue or persecute. Don't stop natural consequences. Be Fair. Be clear with rules and boundaries. Use appropriate structure. Think about safety. Look for slight improvements, and be encouraging.
FAMILY HERO "Everyone's equal and everyone's okay."	Focus on "Who are you?" with Family Hero Child, rather than "What have you achieved." Downplay perfection. Consider if the Hero is being overly-compliant.
MASCOT "This is serious." "That hurts." "That's not funny."	Encourage the Mascot to drop the mask and facade. Ask them to feel and express their feelings. Keep an atmosphere of unconditional positive regard.

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GUIDELINES FOR APPROPRIATE RELATIONSHIPS WITH DYSFUNCTIONAL FAMILY MEMBERS

Chart L

ROLE/Practitioner's Response	Guidelines for Practitioner Behaviors
CHIEF ENABLER "Don't help." "I can do my own job." "Let me back you up."	Take care to have the enabler not help us! The enabler sustains his/her self-esteem by helping whomever they can. Encourage the enabler to relax. Have enabler focus on own feelings and needs. This person has a great deal of anger and must have help with ways to release this heavy load.
VICTIM (Addict) "I'm on your side, and I won't rescue you." "You can do it!" "You can do without anyone's help!"	Avoid offering easy, "black or white" solutions. Build skills and options in this person. Listen for feelings, especially rage and anger. Help this person connect with others in 12-step program. Help her/him discern, with whom in those meetings is it safe to join.
LOST CHILD "Come out, come out wherever you are." "You are important!"	We are careful to not blame or shame this Lost Child. We provide safety and safe boundaries. We promise what we can deliver, are reliable. Support and encourage. Provide do-able tasks toward change.

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EIGHT MOVES TO MAKE FOR MORE POWERFUL PEOPLE EMPOWERING BY CASEWORKERS

Lecturette #6

Addressing practice that empowers clients improves how we feel about our work generally. Having examined varied aspects of the disease of addiction, how to assess and design treatment plans, we are able to consider some general principles to empower the people we work with. These are also summarized in Chart M.

1. Don't promise and don't threaten.

Addicted clients have been threatened and promised their entire lives. It alienates them when we threaten them. They are alienated when we promise and don't deliver. So we should promise only what we can deliver, and, never threaten! If there's a natural consequence for an action, don't hold back. Let the consequence move into center stage.

As identified earlier in this manual, make a written contract and sign it! Make the contract non-threatening, and, be certain their are no promises which can not be delivered upon.

Remember, a good contract starts with, "I'll know that we have successfully completed our relations when . . ." Then, list as many goals as needed.

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As the counselor and practitioner, I may add some goals for consideration, too. Then, we work to make the goals measurable.

e.g. I want to learn to type a page in 12 minutes.

When we both finally agree on the working goals, then we both sign the contract. The client gets a copy and you retain a copy. Assure the client that the copy you have can be copied if they misplace their own.

2. Know what works!

What works best for most is . . .

* 12 step meetings
* working the steps
* having a sponsor

and very often, taking medication as prescribed.

Generally, clients live with their problem everyday, as if they can not live any other way. We should go to a position of seeing solutions. We should identify with clients their existing strengths, their successes in living, etc.

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**Eight Moves to Make
for More Powerful People
Empowering by Caseworkers**
Lecturette #6 (con't)

When recommending AA as a part of the treatment plan, we must suggest strongly that clients need to go to at least 6 open AA meetings to see what this solution is like. Any fewer and they are unable to see the process unfold in themselves. Meetings are always different, even though an underlying rhythm does exist. We must support clients connecting with this deeper experience.

3. Monitor what works.

An interesting way to support consistent monitoring with clients is to ask the same questions every time you see them. Though it is important to begin with general conversation, it is also important to use blatant questions such as

Did you hit your wife?
Did you go to your AA meetings?
Did you drink last weekend?
Did you see your child in placement?

Clients will recognize that you really want the answers to these questions, and, you remember what you are doing there.

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Recognize that eventually patients will lie to you. Notice this, yet, consider the benefit of reacting. Maybe you will confront a lie; maybe you will just take note of this aspect and consider how they are lying. You can use this situation to gain competence in assessing situations and motivations around lying in later sessions with the client. As a rule, it is best to confront a lie only when it can precipitate change.

As a Rule, It is Best to Confront a Lie *Only* When it can Precipitate Change!

AS A RULE

4. Know who's good.

In your community, you need people who are good in treating addicts. Next, you need to know who these people are so you can make referrals. Take time to visit with community drug and alcohol specialists and find out their preferences in client referrals.

It is important to ask whether they are good working with indigent individuals, families and children. Do they feel as comfortable with women as men, with younger addicts or the elder client population?

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Equally important, visit the primary in-patient and out-patient drug and alcohol treatment facilities. Know their procedures for intake and discharge.

5. Don't work harder than the clients do.

When we are working harder than the client, we should examine what's going on. What should the client be doing? How can we get the client going so we can appropriately transfer aspects of the work to them?

We should always recognize that our work is similar to medical triage work. As a worker, we must consider where we need to put our energy to be most effective within the limited time available. Borrowed from the medical triage model, how can we apply this, i.e. some clients you can pour in extensive resources and the outcome is minimally to not at all effective. So, examine how to put dollars with client movement.

Know what you need to do to make decisions, and what you want to do later, when crises are resolved and when internal realities of agency life shift in ways that can become points for reassessment of case work.

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Eight Moves to Make for More Powerful People Empowering by Caseworkers

Lecturette #6 (con't)

6. Don't fall into one of the recognized dysfunctional roles of addicted families.

As identified earlier, these roles include mascot, enabler, hero, addict, lost child, and scapegoat. The likelihood that clients push helpers into these roles is very high. Our job requires we recognize these attempts as attempts at stabilization rather than efforts to simply control us. These roles are "life-significant" as they have provided ways to cope with overwhelming insults and challenges.

The enabler role is most easy for professionals to move toward. Thus, efforts at remaining separated from this psychodynamic process are critical. Some examples include don't get mad at the scapegoat, don't persecute the scapegoat, remember who you don't remember, don't admire and enable the hero, don't blame the victim/addict; and, don't get frustrated with the controlling chief enabler.

7. Stop and think.

Read case materials thoroughly. Review the case history and related notes.

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Eight Moves to Make for More Powerful People Empowering by Caseworkers

Lecturette #6 (concl)

An interesting approach to consider is to make *new* mistakes with the case! Think about what has been working and what hasn't been working in your time with clients. Do not make the mistakes of your predecessor, yet recognize that his/her mistakes were "good" attempts within that earlier time frame.

8. Use supervision.

Last, use supervision regularly. Use supervision as an extra opportunity to think. In supervision, recognize that "two heads" think better than one! Be open to considering different approaches. And, use supervision to consider where your own view of the world may be limiting how you understand and work with a family, a child, or an individual client.

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EIGHT MOVES TO MAKE FOR MORE POWERFUL PEOPLE EMPOWERING BY CASEWORKERS

Chart M

1. Don't promise and don't threaten.
2. Know what works.
3. Monitor what works.
4. Know who's good.
5. Don't work harder than the clients do.
6. Don't fall into one of the recognized dysfunctional roles of addicted families.
7. Stop and think.
8. Use supervision.

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SUGGESTED RESOURCES

Todd, Thomas C, and Matthew D. Selekman (1991). Family Therapy Approaches with Adolescent Substance Abusers. MA: Allyn and Bacon.

VanWormer, Katherine (1995). Alcoholism Treatment: A Social Work Perspective.

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Education and Research Institute for

FOSTERING FAMILIES

APPLICATION FOR CREDIT
ALCOHOL AND SUBSTANCE ABUSE

Name: _____ Social Security #: _____

Address: _____ Phone: _____

_____
(city) (state) (zip)

I. Application for Partial University Credit

Grading: Pass/Fail

The Social Work Department at Colorado State University will grant university credit for each six different modules of training completed. Applications for credit must be made at the Time of Each Module Training ONLY. All work carried out in the modules must meet general academic standards of Colorado State. Written materials must be submitted and receive satisfactory grading for credit to be awarded. These applications will be held until the applicant completes his/her sixth module training. At this point, s/he will be able to formally register through the Division of Continuing Education for 1 credit hour at the current tuition rate set by the University.

_____ Yes, I wish to apply for University credit.

II. Application for Continuing Education Units (CEU's)

Colorado State University, Division of Continuing Education, will grant Continuing Education Units (CEU's) for successful completion of this training session at a cost of $18.00. If you wish to apply for these units, complete the above information, attach a check made payable to CSU, and return this application to the trainer.

_____ Yes, I wish to apply for Continuing Education Units (CEU's) today.

Education and Research Institute for
FOSTERING FAMILIES

Alcohol and Substance Abuse: Confronting Difficult Families
EVALUATION BY PARTICIPANTS

The following items are designed to assess your satisfaction with the training as well as the effectiveness of the training design and materials. Please use the following scale and circle your response.

1 - not well addressed in the training
2 - not as adequately addressed as necessary
3 - adequate; given sufficient attention
4 - well addressed in the training
5 - very well addressed in the training

		Not Well Addressed				Very Well Addressed
1.	Identify and recognize denial as a primary factor in addressing substance abuse issues in child protection.	1	2	3	4	5
2.	Distinguish between social use and addictive use of mood-altering substances.	1	2	3	4	5
3.	Learn new ways to relate to client family members in the interview and assess the needs of family members.	1	2	3	4	5
4.	Be able to identify the complexities for assessment and treatment planning with client family members with dual and multiple diagnoses where one of the diagnoses is substance abuse.	1	2	3	4	5
5.	Gain competence in planning treatment strategies using knowledge of different levels of treatment intervention and thereafter succeeding in the monitoring and coordination of the case plan.	1	2	3	4	5

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B. The following items relate to program aspects of the training module. Please rate these items on the following scale. Any additional comments are welcome in the space provided after the question.

1 = Very Poor
2 = Poor
3 = Adequate
4 = Good
5 = Very Good

	Very Poor	Poor	Adequate	Good	Very Good
1. The length of the training (Was the material covered in the time allotted?)	1	2	3	4	5
2. Usefulness of training manual	1	2	3	4	5
3. Participant responsiveness	1	2	3	4	5
4. Your ability to participate expressing your ideas, feelings, and concerns	1	2	3	4	5
5. Your interest in the training session	1	2	3	4	5
6. Your comprehension of the material presented	1	2	3	4	5

COMMENTS: Please be specific:

C. We are interested in your feedback about our trainer, co-trainer(s). With this feedback we can continue to improve our sessions.

1 = Totally inadequate and ineffective
2 = Generally inadequate and ineffective
3 = About half and half
4 = Usually adequate and effective
5 = Highly adequate and effective

	Totally Ineffective/ Inadequate		0		Highly Effective/ Adequate
1. Knowledge/mastery of the subject matter	1	2	3	4	5
2. Preparation	1	2	3	4	5
3. Ability to communicate	1	2	3	4	5
4. Style of presentation	1	2	3	4	5
5. Enthusiasm/interest in subject matter	1	2	3	4	5
6. Overall performance	1	2	3	4	5
7. Ability to facilitate	1	2	3	4	5

8. In general, what would you identify as the strengths of trainer(s)?

9. In general, what would you identify as the deficiencies of trainer(s)?

D. The training setting is obviously an important aspect of a sessions success. We are interested in your feedback regarding the location, room, etc., and again welcome any comments or suggestions.

	Very Poor	Poor	Adequate	Good	Very Good
1. Setting appropriate for concentration, i.e., distraction, noise, temperature.	1	2	3	4	5
2. Setting conducive for participation	1	2	3	4	5

COMMENTS: Please be specific:

E. Overall Comment: What could have been done differently to make the training sessions more beneficial or helpful to you? (Please use back of page if necessary).

I.D. #_ _ _ _

FOSTER CARE DEMOGRAPHICS

E. **DIRECTIONS: Please fill in all blanks with information where needed or circle the correct number where several choices are provided on the next two pages.**

1. Last 4 #'s of Social Security # _ _ _ _

2. Circle correct role: 1. worker 2. foster parent 3. Other_____ (please specify)

3. Date _ _ - _ _ - _ _

4. County _____

5. Circle gender: 1. Male 2. Female

6. Circle racial background:
   1. Hispanic
   2. Black, not of Hispanic origin
   3. Asian-American
   4. American Indian
   5. White, not of Hispanic origin
   6. Other:_____

7. Age_____

8. Are you (please circle one): 1. Married 2. Separated 3. Single

9. Number of birth & adopted female children_____

10. Number of birth & adopted male children_____

11. Circle age group of birth & adopted children:

    1. all under 5
    2. all under 10
    3. all under 15
    4. all under 18
    5. all over 18
    6. some under 18 & others over 18
    7. none

12. Highest level of formal education: (please circle one)

    1. some high school
    2. high school graduate
    3. some college
    4. college graduate
    5. Master's degree or higher

13. Within the past year, have you participated in any other foster care training other than Colorado State's Fostering Families?

    1. yes 2. no

Thank you for your help! Your feedback is important for our continuing improvement of the Fostering Families project.

PLEASE CONTINUE TO THE NEXT PAGE

F. **DIRECTIONS: Finally! Complete only the section which refers to you as either a Foster Care Parent or Foster Care Worker.**

FOSTER CARE PARENT SECTION

14. What type of agency are you employed or licensed through?

1. County Department of Social Services
2. Private Child Placing Agency (please specify)_____
3. Both County Department of Social Servoces and Private.
4. Indian/Tribal
5. Other please specify) _____

15. Total # of children presently in home_____
16. Number of foster female children_____
17. Number of foster male children_____

18. Circle age group of foster children:

1. all under 5
2. all under 10
3. all under 15
4. all under 18
5. all over 18
6. some under 18 & some over 18
7. no children now
8. not yet foster parents
9. other_____

19. Is at least one parent in the home providing parenting and supervision?

1. Yes 2. No, Parent(s) have work responsibilities outside of the home.

20. Length of involvement as foster family: _____years
21. Number of foster children for which licensed_____
22. Total number of foster children since being a foster parent_____

23. Circle general age groups of foster children you have served:

1. 0 - 24 mos.
2. 1 - 6 years
3. 0 - 12 years
4. 0 - 18 years
5. 0 - 21 years
6. short term/emergency

FOSTER CARE WORKER SECTION

24. What type of agency are you employed or licensed through?

1. County Department of Social Services
2. Private Child Placing Agency (please specify) _____
3. Indian/Tribal
4. Other _____ (please specify)

25. Are you currently employed as a foster care worker? 1. Yes 2. No

26. Length of time in current agency _____years

27. Current title:

1. Caseworker I
2. Caseworker II
3. Caseworker III
4. Supervisor I
5. Supervisor II
6. Foster Case Trainer
7. Other (specify) _____

28. Length of time in current position _____years
29. Length of time in protective services/foster care unit _____years